MassHealth

Billing Guide for Paper Claim Form No. 4

Executive Office of Health and Human Services
MassHealth
July 2007

BG-4-CL (07/07)

Table of Contents

Introduction

The following information describes in detail how to bill on the paper claim form no. 4. For administrative and billing instructions, see Subchapter 5 of your MassHealth provider manual.

For information about the resulting remittance advice, see the Guide to Remittance Advice and Electronic Equivalents for Claim Form No. 4.

General Instructions for Submitting Paper Claims

Claim Form No. 4

The providers listed below may use claim form no. 4 (Request for Payment - EPSDT) when submitting paper claims to MassHealth for services related to well-child-care visits provided in accordance with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule, for a member under 21 years old with third-party liability (TPL):

- community health centers;
- independent nurse midwives;
- independent nurse practitioners; and
- physicians.

Additional Information

Claim form no. 4 is used to submit claims for newborn and well-child screening visits and laboratory, hearing, and vision tests provided in accordance with the EPSDT Schedule. Use claim form no. 4 to bill only for these services. Refer to Appendix W of your MassHealth provider manual for the EPSDT Schedule.

To bill for additional diagnosis and treatment services provided in accordance with the EPSDT Schedule to children under 21 with TPL, community health centers should use claim form no. 9, and physicians, independent nurse midwives, and independent nurse practitioners should use claim form no. 5.

For more information about well-child care and the EPSDT Schedule, see MassHealth regulations at 130 CMR 450.140 through 450.150 and Appendix W of your MassHealth provider manual.

You may request supplies of claim form no. 4 by submitting a request to the MassHealth address found in Appendix A of your MassHealth provider manual.

Entering Information on Claim Form No. 4

Follow these guidelines when filling out the claim form.

- Complete a separate claim form for each member to whom services were provided.
- Type or print all applicable information (as stated in the instructions) on the claim form, using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as “same as above.”

- Attach any necessary reports or required forms to the claim form.
- When a required entry is a date, enter the date in MMDDYY format.

  Example: For a member born on February 28, 2001, the entry in Item 9 (Date of Birth) would be as follows.

022801

Time Limitations on the Submission of Claims

The period fixed by statute (M.G.L. c. 118E, § 20) for the submission of claims is 90 days, measured from the date of service or the date on the explanation of benefits (EOB) from another insurer to the date on which the claim form is received by MassHealth. For regulations governing time limitations on the submission of claims, see the billing regulations in Subchapter 3 of your MassHealth provider manual.

Since the 90-day requirement applies to each claim line, the claim form must be received within 90 days from the earliest date of service on the form.

All services listed on a single claim line must have been provided in the same fiscal year. That is, if you are allowed to submit consecutive dates of service on a single claim line ("from and thru" billing), dates of service from the months of June and July should never appear on the same claim line.

For additional information about submitting claims, consult the administrative and billing instructions in Subchapter 5 of your MassHealth provider manual.

Claims for Members with Other Health Insurance Coverage

Use claim form no. 4 only to bill claims for newborn and well-child screening visits and laboratory, hearing, and vision tests provided in accordance with the EPSDT Schedule for members under age 21 who have TPL coverage.

Claims for members under 21 **without** TPL coverage cannot be submitted on claim form no. 4. They must be submitted to MassHealth according to the administrative and billing instructions contained in Subchapter 5 of your MassHealth provider manual.

Electronic Claims

Claims for services related to well-child visits provided in accordance with the EPSDT Schedule may be submitted electronically.

To submit electronic claims, contact MassHealth Customer Service. Refer to Appendix A of your MassHealth provider manual for contact information. Additional information is also available in Subchapter 5 of your MassHealth provider manual.

Where to Send Paper Claim Forms

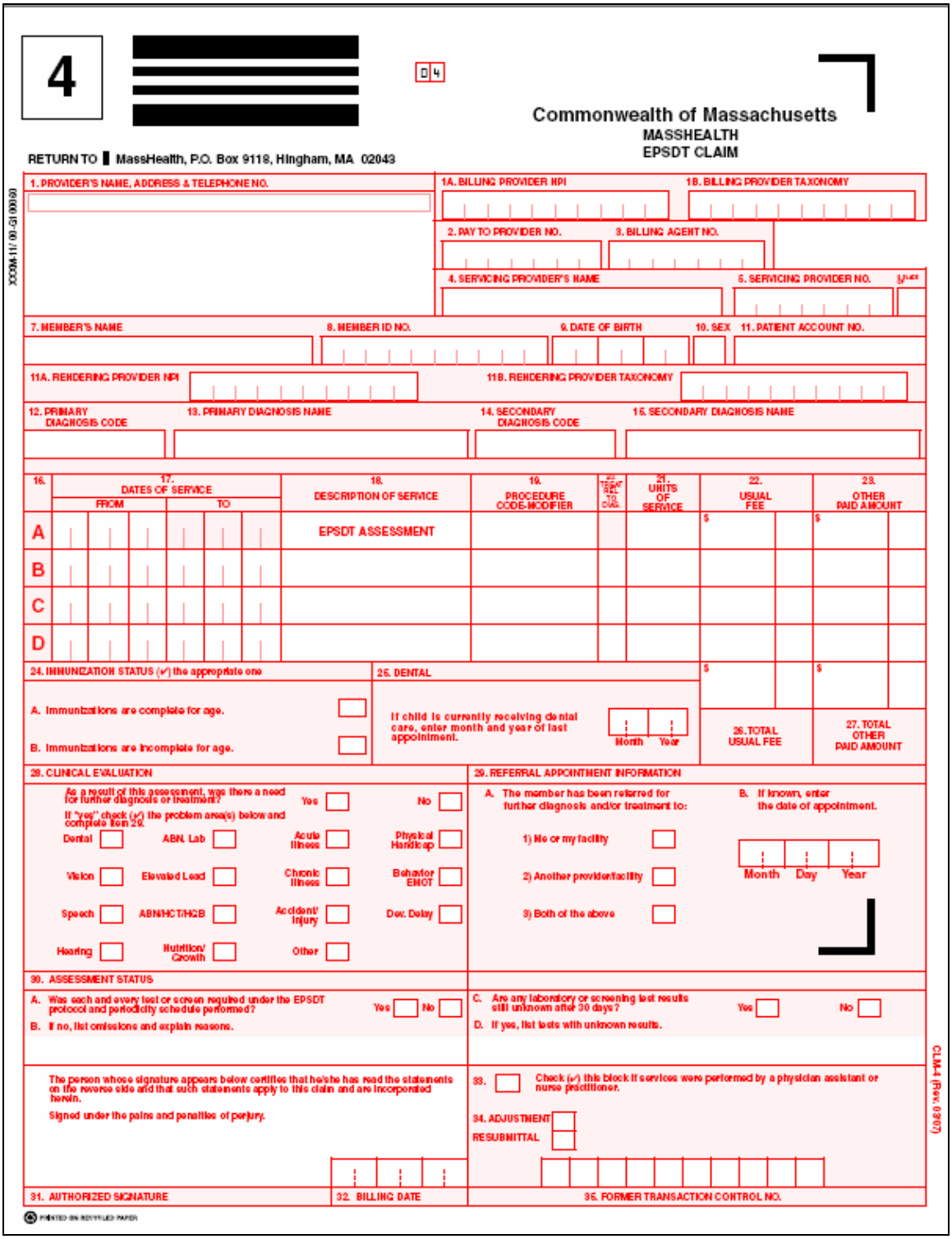
Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following item-by-item instructions, you need additional assistance to complete claim form no. 4, you can contact MassHealth Customer Service. Please refer to Appendix A of your MassHealth provider manual for all MassHealth Customer Service contact information.

Item-by-Item Instructions for Claim Form No. 4

A sample claim form no. 4 is shown below.



4

[redacted]

04

Commonwealth of Massachusetts
MASSHEALTH
EPSDT CLAIM

RETURN TO [redacted] MassHealth, P.O. Box 9118, Hingham, MA 02043

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
1A. BILLING PROVIDER NPI
1B. BILLING PROVIDER TAXONOMY
2. PAY TO PROVIDER NO.
3. BILLING AGENT NO.
4. SERVICING PROVIDER'S NAME
5. SERVICING PROVIDER NO.
7. MEMBER'S NAME
8. MEMBER ID NO.
9. DATE OF BIRTH
10. SEX
11. PATIENT ACCOUNT NO.
11A. RENDERING PROVIDER NPI
11B. RENDERING PROVIDER TAXONOMY
12. PRIMARY DIAGNOSIS CODE
13. PRIMARY DIAGNOSIS NAME
14. SECONDARY DIAGNOSIS CODE
15. SECONDARY DIAGNOSIS NAME

16.	17. DATES OF SERVICE FROM	17. DATES OF SERVICE TO	18. DESCRIPTION OF SERVICE	19. PROCEDURE CODE-MODIFIER	20. EPSDT REF. LAB CHK.	21. UNITS OF SERVICE	22. USUAL FEE	23. OTHER PAID AMOUNT
A			EPSDT ASSESSMENT				$	$
B								
C								
D								

24. IMMUNIZATION STATUS (✓) the appropriate one
A. Immunizations are complete for age.
B. Immunizations are incomplete for age.

25. DENTAL
If child is currently receiving dental care, enter month and year of last appointment. Month Year

26. TOTAL USUAL FEE
27. TOTAL OTHER PAID AMOUNT

28. CLINICAL EVALUATION
As a result of this assessment, was there a need for further diagnosis or treatment? Yes No
If "yes" check (✓) the problem area(s) below and complete item 29.
Dental, ABN Lab, Acute Illness, Physical Handicap
Vision, Elevated Lead, Chronic Illness, Behavior EMOT
Speech, ABN/HCT/HGB, Accident/ Injury, Dev. Delay
Hearing, Nutrition/ Growth, Other

29. REFERRAL APPOINTMENT INFORMATION
A. The member has been referred for further diagnosis and/or treatment to:
1) Me or my facility
2) Another provider/facility
3) Both of the above
B. If known, enter the date of appointment. Month Day Year

30. ASSESSMENT STATUS
A. Was each and every test or screen required under the EPSDT protocol and periodicity schedule performed? Yes No
B. If no, list omissions and explain reasons.
C. Are any laboratory or screening test results still unknown after 30 days? Yes No
D. If yes, list tests with unknown results.

The person whose signature appears below certifies that he/she has read the statements on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

33. Check (✓) this block if services were performed by a physician assistant or nurse practitioner.
34. ADJUSTMENT
RESUBMITTAL

31. AUTHORIZED SIGNATURE
32. BILLING DATE
35. FORMER TRANSACTION CONTROL NO.

CLM-1 (Rev. 03/07)

PRINTED ON RECYCLED PAPER

Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item No.	Item Name	Description
1	Provider's Name, Address & Telephone No.	Enter the provider's name, address, and telephone number.
1A	Billing Provider NPI	Enter your billing (pay-to) NPI. Your MassHealth payment will be issued to this number. If a group practice is the pay-to provider, complete Item 11A, and if instructed to do so by MassHealth, complete Item 11B.
1B	Billing Provider Taxonomy	Enter the taxonomy code applicable for the billing (pay-to) NPI only if instructed to do so by MassHealth.
2	Pay to Provider No.	Leave this item blank.
3	Billing Agent No.	If this form is prepared by a billing agent, enter the seven-digit number assigned to the agent. If one was not assigned, leave this item blank.
4	Servicing Provider's Name	Leave this item blank.
5	Servicing Provider's No.	Leave this item blank.
6	Place of Service	Enter the code from the list below that describes the place where the service was provided. 01 - Office, facility, business location 03 - Inpatient hospital 04 - Outpatient hospital 10 - School-based health center
7	Member's Name	Enter the name of the member receiving services.
8	Member's ID No.	Enter the complete 10-character member identification number that is printed on the MassHealth card below or beside the member's name. The member ID number on the temporary MassHealth card may include an asterisk as the 10th character.
9	Date of Birth	Enter the member's date of birth in MMDDYY format.
10	Sex	Enter an "X" in the appropriate box to indicate the member's gender.
11	Patient Account No.	Enter the member's patient account number, if one is assigned. If one is not assigned, enter the member's last name.

Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item No.	Item Name	Description
11A	Rendering Provider NPI	If a group practice number was entered in Item 1A, enter the NPI of the provider who furnished the service.
11B	Rendering Provider Taxonomy	If an entry was made in Item 11A, and if instructed by MassHealth to supply your taxonomy code, enter the 10-digit taxonomy code of the provider listed in Item 11A.
12	Primary Diagnosis Code	Enter the appropriate ICD-9-CM diagnosis code for the primary diagnosis, if applicable.
13	Primary Diagnosis Name	Enter the appropriate diagnosis name for the primary diagnosis code entered in Item 12, if applicable.
14	Secondary Diagnosis Code	Enter the appropriate ICD-9-CM diagnosis code for the secondary diagnosis, if applicable.
15	Secondary Diagnosis Name	Enter the appropriate diagnosis name for the secondary diagnosis code entered in Item 14, if applicable.
16 A-D		Each letter (A through D) refers to one of the four claim lines on the claim form. This letter will appear as the last character of the claim's transaction control number (TCN) listed on a remittance advice. Line A should be used only for well-child visits provided in accordance with the EPSDT Schedule. Lines B through D should be used for laboratory, hearing, and vision tests, and for newborn care provided in the hospital other than the discharge visit. Do not use lines B through D to bill for well-child visits provided in accordance with the Schedule.
17	Date of Service: From/To	Enter the date the service was provided in MMDDYY format. *For a single date of service*: In "From," enter date the service was provided in MMDDYY format. Leave "To" blank. *For consecutive dates of service*: In "From," enter the first date of service. In "To," enter the last date of service.

Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item No.	Item Name	Description
18	Description of Service	*Line A* Do not enter any additional information on this line. *Lines B-D* Enter a brief description of the service furnished. If more space is required for the service description, attach an additional sheet of paper. See Item 16 for more explanation of the services that should be claimed on these lines. *Laboratory Tests* Enter the name of the test. *Medical supplies and medications* Independent nurse midwives, independent nurse practitioners, and physicians must include a complete description of any medical supplies and medications for this item, including the acquisition cost and the quantity dispensed. For medical supplies, indicate whether the item is standard or custom made. For medications, include the name, strength, and dosage.
19	Procedure Code-Modifier	Enter the service code and any applicable modifier code that corresponds to the service provided. See Subchapter 6 of your MassHealth provider manual for a list of payable and nonpayable service codes. When billing for a service code that requires a report, attach a copy of that report to the claim form.
20	Treat Rel. to Diag.	Leave this item blank.
21	Units of Service	Enter the total number of days or units of the service that was provided. When billing for consecutive days of service, enter the total number of days within the billing period. When billing for nonconsecutive dates of service, enter "1" for each date of service entered on the claim form.

Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item No.	Item Name	Description
22	Usual Fee	Enter the provider's usual and customary fee for the service (amount charged to a person who is not a MassHealth member).
23	Other Paid Amount	Enter any amount that the provider received from the member's other insurance. Any amount entered in Item 23 will be deducted from the MassHealth payment.
24	Immunization Status	Check the appropriate box to indicate whether the member's immunizations are complete or incomplete according to the EPSDT Schedule.
25	Dental	If known, enter the date of the member's last dental appointment in MMDDYY format.
26	Total Usual Fee	Leave this item blank.
27	Total Other Paid Amount	Leave this item blank.
28	Clinical Evaluation	Check the appropriate box to indicate whether the need for further diagnosis and/or treatment was detected during the visit. If "Yes" is checked, check the appropriate problem-area boxes, and complete Item 29. If "No" is checked, skip Item 29.
29	Referral Appointment Information	This item refers to the appointment(s) for which a member is referred to receive further diagnosis and/or treatment. The provider to whom a member is referred for this appointment will not necessarily be the same provider who provides ongoing care to the member for any diagnoses. *Part A* If "Yes" is checked in Item 28, check the appropriate field to indicate to whom the member was referred. *Part B* If the provider has referred the member to himself or herself or his or her facility for further diagnosis and/or treatment, enter the appointment date in MMDDYY format. Otherwise, the provider should enter only the date of the appointment if the provider knows the date.

Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item No.	Item Name	Description
30	Assessment Status	*Part A* Indicate whether each and every assessment (screening test) required under the EPSDT Schedule (see Appendix W of your MassHealth provider manual), including immunizations, was performed. *Part B* If Part A is checked "No," describe any omission and explain this omission. *Part C* Indicate whether any laboratory or screening test results are still unknown after 30 days. *Part D* If Part C is checked "Yes," list the screening tests with unknown results.
31	Authorized Signature	The claim form must be signed by the provider or by an individual designated by the provider to certify that the information entered on the form is correct. Signatures other than handwritten signatures (for example, those by stamp, typewriter, or mechanically applied) are acceptable.
32	Billing Date	Enter in MMDDYY format the date on which the claim form is completed. This date cannot be before the last date of service on the form.
33	(Unlabeled)	Check this item if any of the services were performed by a physician assistant, a non-independent nurse practitioner, or a non-independent nurse midwife employed by a physician.
34	Adjustment/Resubmittal	If the claim is an adjustment or resubmittal, check the appropriate box. Use the resubmittal option for certain claims over 90 days. Do not make any entry in this item without completing Item 35. For additional information about correcting claims, consult Subchapter 5 of your MassHealth provider manual.

Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item No.	Item Name	Description
35	Former Transaction Control No.	If either box in Item 34 is checked, then an entry is required. Enter the 10-character transaction control number (TCN) assigned to the original claim that is being adjusted or resubmitted. The TCN appears on the remittance advice that listed the original claim as paid or denied. Refer to Subchapter 5, Part 7 of your MassHealth provider manual before attempting to adjust or resubmit claims. Incorrect use of the TCN may result in denied claims.